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PTO/SB/82 (11-96)  
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Patent and Trademark Office, U.S. DEPARTMENT OF COMMERCE  
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<b>REVOCATION OF POWER OF ATTORNEY OR AUTHORIZATION OF AGENT</b>	Application Number	09/981,938
	Filing Date	October 17, 2001
	First Named Inventor	DeCesare
	Group Art Unit	2834
	Examiner Name	TBA
	Attorney Docket Number	DeCesare 1

I hereby revoke all previous powers of attorney or authorizations of agent given in the above-identified application:

☐ A Power of Attorney or Authorization of Agent is submitted herewith.

OR

☒ Please change the correspondence address for the above-identified application to:

☐ Customer Number  →

Place Customer  
Number Bar Code  
Label here

<input checked="" type="checkbox"/> Firm or Individual Name	Mr. Vito DeCesare				
Address					
Address	220 West Jersey Street				
City	Elizabeth				
Country	United States	State	NJ	ZIP	07202
Telephone		Fax			

I am the:

☐ Applicant.

☒ Assignee of record of the entire interest  
Certificate under 37 CFR 3.73(b) is enclosed

**SIGNATURE of Applicant or Assignee of Record**

Name	Vito DeCesare
Signature	<i>Vito DeCesare</i>
Date	7/10/2002

Burden Hour Statement: This form is estimated to take 0.2 hours to complete. Time will vary depending upon the needs of the individual case. Any comments on the amount of time you are required to complete this form should be sent to the Chief Information Officer, Patent and Trademark Office, Washington, DC 20231. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Assistant Commissioner for Patents, Washington, DC 20231.

Estate #: 19998  
3/4/02 - JCS

State of New Jersey  
Union County Surrogate's Court

In the Matter of the Estate of:  
DOMINIC DE CESARE (Never Married), Deceased

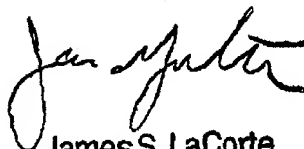
} EXECUTOR  
SHORT CERTIFICATE

I, James S. La Corte, Surrogate do hereby certify that the Last Will of the above named decedent, late of the County of Union and State of New Jersey, was admitted to Probate by the Surrogate of Union County, on MAR 11 2002 and that Letters Testamentary were issued to:

VITO DE CESARE

the Executor named therein, who is duly authorized to take upon himself the administration of the estate of said testator agreeably to the said Will, and said Letters Testamentary have never been revoked and still remain in full force and effect.

WITNESS my hand and seal of office, this  
11th day of March, 2002



James S. LaCorte  
Surrogate & Deputy Clerk of Superior Court of NJ  
Chancery Division, Probate Part, Union County

REG-18  
AUG 99

NEW JERSEY DEPARTMENT OF HEALTH AND SENIORS  
**CERTIFICATE OF DEATH**

STATE USE ONLY

1. NAME OF DECEASED (First) <b>DOMINIC</b>		(Middle)		(Last) <b>DE CESARE</b>		STATE USE ONLY	
2. DATE OF DEATH <b>2-27-02</b>	3. SEX <b>M</b>	4. DATE OF BIRTH <b>12-17-15</b>	5a. AGE - Last Birth day (yrs.) <b>86</b>	5b. UNDER 1 YEAR Months Days Hours Minutes	5c. UNDER 1 DAY Hours Minutes		
6. SOCIAL SEC. NO. <b>139-36-7850</b>		7a. PLACE OF DEATH HOSPITAL: <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify)			
7b. FACILITY NAME (if not institution, give street and no.) <b>TRINITY HOSPITAL</b>		7c. CITY/TOWN OR LOCATION <b>ELIZABETH</b>		7d. COUNTY <b>UNION</b>			
8a. RESIDENCE (State) <b>N.J.</b>	8b. COUNTY <b>UNION</b>	8c. CITY OR TOWN <b>ELIZABETH</b>	8d. STREET AND NUMBER <b>223 CENTRE ST</b>		8e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	8f. ZIP CODE <b>07202</b>	
9. BIRTHPLACE (City & State, or Foreign Country) <b>ELIZABETH, N.J.</b>		10a. DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10b. IF YES, WAR: DATES (From-To): <b>WW II 8/14/42-7/10/46</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	
12. SURVIVING SPOUSE (If Wife, Maiden Name)		13. USUAL OCCUPATION (Kind of work done most of life, or if retired)		14. KIND OF BUSINESS OR INDUSTRY			
		<b>ADMINISTRATOR</b>		<b>U.S. GOVERNMENT</b>			
15. NAME AND ADDRESS OF LAST EMPLOYER <b>DEPARTMENT OF DEFENSE NEW YORK CITY NEW YORK</b>							
16. RACE 1 <input checked="" type="checkbox"/> WHITE 2 <input type="checkbox"/> BLACK		3 <input type="checkbox"/> AMER. INDIAN 4 <input type="checkbox"/> OTHER (Specify):		17. OF HISPANIC ORIGIN? IF YES, SPECIFY: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		18. DECEDENT'S EDUCATION Highest Grade Completed <b>12 TH</b>	
19. NAME OF FATHER (First) (Middle) (Last) <b>Michael DeCesare</b>		20. MAIDEN NAME OF MOTHER (First) (Middle) (Last) <b>VINCENZA CAPOZZI</b>					
21a. NAME OF INFORMANT <b>ANTHONY DECESARE</b>		21b. RELATIONSHIP <b>Brother</b>		22a. DISPOSITION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT		22b. OTHER (Specify):	
22b. NAME OF CEMETERY OR CREMATORY <b>Roseville-Rosehill Cemetery Assoc.</b>		22c. CITY OR TOWN <b>Linden</b>		22d. STATE <b>N.J.</b>			
23a. NAME AND ADDRESS OF FUNERAL HOME <b>PETRUCCELLI FUNERAL HOME 23 LEANSTINE STREET ELIZABETH, NEW JERSEY</b>							
23b. SIGNATURE OF FUNERAL DIRECTOR <b>Major E. Belmont Blair</b>		23c. N.J. LICENSE NO. <b>2566</b>		24a. SIGNATURE OF LOCAL REGISTRAR <b>Gail Smith</b>		24b. DATE RECEIVED <b>3-1-02</b>	
25a. TIME OF DEATH <b>12:48 A.M.</b>		25b. DATE AND HOUR PRONOUNCED DEAD DATE: <b>2-27-02</b>		HOUR: <b>12:48 A.M.</b>		25d. DATE SIGNED <b>2/28/02</b>	
Complete Items 25c-d only when certifying physician is not available at time of death to certify cause of death.		25c. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT (TIME, DATE, AND PLACE INDICATED). SIGNATURE OF PRONOUNCER (If different than certifier): <b>DECA &amp; Valera on</b>				25d. DATE SIGNED <b>2/28/02</b>	
26. PART I: IMMEDIATE CAUSE (Final disease or condition resulting in death). Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.		IMMEDIATE CAUSE (Enter the disease, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or instant killing. List only one cause on each line.) a. <b>Cardiopulmonary arrest</b> b. DUE TO OR AS A CONSEQUENCE OF: c. <b>Orchestral myocardial infarction</b> d. DUE TO OR AS A CONSEQUENCE OF:				INTERVAL BETWEEN ONSET AND DEATH	
PART II: Other significant conditions - contributing to death but not related to underlying cause in PART I.							
27. IF FEMALE, WAS SHE PREGNANT AT DEATH, OR ANY TIME 90 DAYS PRIOR TO DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29. DEATH DUE TO: <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		<input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED		30a. DATE OF INJURY		30b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
30c. PLACE <input type="checkbox"/> STREET <input type="checkbox"/> OTHER (Specify):		30d. HOME <input type="checkbox"/> OFFICE BUILDING <input type="checkbox"/> FARM <input type="checkbox"/> FACTORY		30e. DESCRIBE HOW INJURY OCCURRED			
30f. LOCATION OF INJURY (Number and Street)				30g. CITY AND COUNTY		30h. STATE	
31a. NAME AND ADDRESS OF CERTIFIER <b>DECA &amp; Valera on 1200 WOODLAND</b>						31b. CERTIFYING PHYSICIAN MEDICAL EXAMINER PRONOUNCER AND CERTIFIER	
31b. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED DUE TO CAUSES LISTED ABOVE. SIGNATURE OF CERTIFIER: <b>Gail Smith</b>						31c. DATE SIGNED <b>2/28/02</b>	

H4787



**CITY OF ELIZABETH, N. J.  
OFFICE OF REGISTRAR OF VITAL STATISTICS**

MAP 1

(Date)

THIS IS TO CERTIFY THAT THE FOREGOING IS A TRUE COPY OF A RECORD IN MY OFFICE.

Warning: Do not accept this copy unless the raised seal of the City of Elizabeth, N. J. is affixed hereon.

*Gail Smith*  
Registrar of Vital Statistics  
City Hall, Elizabeth, N. J.



COPY OF PAPERS  
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2834

Please type a plus sign (+) inside this box → ☐

PTO/SB/21 (08-00)

Approved for use through 10/31/2002. OMB 0651-0031

U.S. Patent and Trademark Office: U.S. DEPARTMENT OF COMMERCE

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

<b>TRANSMITTAL FORM</b> <i>(to be used for all correspondence after initial filing)</i>	<b>Application Number</b>	09/981,938	
	<b>Filing Date</b>	10/17/2001	
	<b>First Named Inventor</b>	DeCesare	
	<b>Group Art Unit</b>	2834	
	<b>Examiner Name</b>	TBA	
<b>Total Number of Pages in This Submission</b>	4	<b>Attorney Docket Number</b>	DeCesare 1

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ENCLOSURES (check all that apply)		
<input type="checkbox"/> Fee Transmittal Form	<input type="checkbox"/> Assignment Papers (for an Application)	<input type="checkbox"/> After Allowance Communication to Group
<input type="checkbox"/> Fee Attached	<input type="checkbox"/> Drawing(s)	<input type="checkbox"/> Appeal Communication to Board of Appeals and Interferences
<input type="checkbox"/> Amendment / Reply	<input type="checkbox"/> Licensing-related Papers	<input type="checkbox"/> Appeal Communication to Group (Appeal Notice, Brief, Reply Brief)
<input type="checkbox"/> After Final	<input type="checkbox"/> Petition	<input type="checkbox"/> Proprietary Information
<input type="checkbox"/> Affidavits/declaration(s)	<input type="checkbox"/> Petition to Convert to a Provisional Application	<input type="checkbox"/> Status Letter
<input type="checkbox"/> Extension of Time Request	<input checked="" type="checkbox"/> Power of Attorney, Revocation Change of Correspondence Address	<input checked="" type="checkbox"/> Other Enclosure(s) (please identify below):
<input type="checkbox"/> Express Abandonment Request	<input type="checkbox"/> Terminal Disclaimer	Return Post Card
<input type="checkbox"/> Information Disclosure Statement	<input type="checkbox"/> Request for Refund	
<input type="checkbox"/> Certified Copy of Priority Document(s)	<input type="checkbox"/> CD, Number of CD(s) _____	
<input type="checkbox"/> Response to Missing Parts/Incomplete Application	<b>Remarks</b>	
<input type="checkbox"/> Response to Missing Parts under 37 CFR 1.52 or 1.53		

SIGNATURE OF APPLICANT, ATTORNEY, OR AGENT	
Firm or Individual name	Vincent E. McGeary, Reg. No. 42,862 Gibbons, Del Deo, Dolan, Griffinger & Vecchione
Signature	
Date	07/24/2002

CERTIFICATE OF MAILING	
I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to: Commissioner for Patents, Washington, DC 20231 on this date: 07/24/2002	
Typed or printed name	Rosangela Medina
Signature	
Date	07/24/2002

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